2026 CLIENT PROFILE Mail to: Mid-Michigan Insurance Advisors 475 N. State St Ste A Caro MI 48723 Phone: 989-672-8880 Fax: 989-672-8881										
First Name:N	/liddl	e Initia	l: La	st Nam	ne:					
Address:										
Home:Cell	:			Er	mail:					
SECTION A: Please place										
I take ALBUTEROL SULFATE or INSULIN										
Due to limited appointment times, we are coverage options for next year. Please se recommendation: I plan to make an in office appointment I plan to make a telephone appointment Please email me your recommendation of Please mail me your recommendation on	elect	your p	referred meth	od of o	corresponde	nce regarding	your plan			
If you would like to verify that you are not over paying for your Medicare Supplement or Medicare Advantage plan, please indicate the plan that you currently have and your current premium amount. Company Premium per month:										
SECTION B: Please provide the following information FROM THE LABELS ON YOUR PRESCRIPTION DRUG CONTAINERS.										
FULL NAME OF DRUG * Without an "X" in the "I take Generic" or "I take Name Brand" columns, Medicare defaults to the generic equivalent if available.	I take GENERIC	I take NAME BRAND	DOSAGE STRENGTH Examples: 50 mg tab, 400 mg cap, 3.5 oz. tube,	FR	EQUENCY Examples: 2 / Day, 1 / Week, 8 / Month	REFILL QTY Number of tablets, capsules, patches, etc. in container	REFILL FREQUE NCY 30 Days, 90 Days, 6 months, Yearly, etc.			
EXAMPLE: Metoprolol Succinate ER EXAMPLE: Synthroid	X	X	50 MG 112 MCG		1/DAY 1/DAY	30 90	30 DAYS 60 DAYS			
I am willing to use Mail Order to save money		YES / NO	l prefe	er to use Mai	l Order	YES / NO				
Pharmacies I prefer to use										
Pharmacy I am NOT willing to use							•			
* NOTE: Please list and provide accurate information for your <u>current</u> prescription drugs only and be sure to denote CR, ER, HCL, HCTZ, SR or XL after the full name of the drug when applicable. Please <u>DO NOT INCLUDE</u> any over-the-counter medications, non-prescription vitamins, drugs you receive at the hospital or free-of-charge from your doctor, or any prescription drugs you will not be purchasing through your prescription drug plan.										
Client's Signature:					Dat	e:/_	/20			

SECTION C:

Provide us with specific information for each type of INSULIN that you take.

Insulin Brands: Apidra, Humalog, Humulin, Lantus, Levemir, Novolin, Novolog

1. I use insulin PENS						
Pen #1:						
Name of insulin pen:			e:			
Mix/concentration:Nur	mber of pe	ns in a package:	Pens per mo	nth:		
Pen #2:						
Name of insulin pen:		Pen size	e:	ml		
Mix/concentration:Nur	mber of pe	ns in a package:	Pens per mo	nth:		
	SECTI	ON D:				
Provide us with specific inform	ation fo	r each type of	ALBUTEROL S	SUIFATE		
Trovide us with specific inform			ALBOILNOL	OLIAIL		
ENGINEER SEATTLE SEE SEE	that yo	и таке.				
1. I use an <i>HFA INHALER</i> .						
Inhaler #1: Brand Name of HFA Inhaler:				gm.		
Inhaler is used: [] daily [] monthly [] as no						
Spiriva: Number of aerosols per box:	Refill	quantity:	_ boxes every	days		
Inhaler #1: Brand Name of HFA Inhaler:			Inhaler size:	gm.		
Inhaler is used: [] daily [] monthly [] as no						
Spiriva: Number of aerosols per box:	Refill	quantity:	_ boxes every	days		
2. I use a NEBULIZER VIAL.						
Name:	_Vial size:	ml Mix/	concentration:			
Number of vials in a package:	Number of vials used per month					
If you have any friends or family that are overpaying, please provide their contact if I can help in any way. Thank you.				-		
Name			Telephone numbe	r		
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